

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS4529SNF	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/01/2009
NAME OF PROVIDER OR SUPPLIER LAS VENTANAS RETIREMENT COMM SNF		STREET ADDRESS, CITY, STATE, ZIP CODE 10401 WEST CHARLESTON BLVD LAS VEGAS, NV 89135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z 000	<p>Initial Comments</p> <p>Surveyor: 26251 This Statement of Deficiencies was generated as a result of complaint investigation conducted at your facility on December 1, 2009 in accordance with Nevada Administrative Code, Chapter 449, Facilities for Skilled Nursing.</p> <p>Complaint #NV00023156 was substantiated without deficiencies cited.</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.</p> <p>No further action is necessary. Please retain a copy of this report for your records.</p>	Z 000		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE